



**HEALTH CHECKLIST  
FOR EMERGENCY/TEMPORARY CARE**

Name \_\_\_\_\_ Date \_\_\_\_\_

Facility \_\_\_\_\_ Interviewer \_\_\_\_\_

1. Are you having any health problems at the present time? Yes \_\_\_\_\_ No \_\_\_\_\_  
Describe \_\_\_\_\_

2. Have you had any of the following problems in the past 24 hours?

	YES	NO		YES	NO		YES	NO
Sore Throat			Nausea/Vomiting			Diarrhea		
Earache			Headache			Abdominal Pain		
Swollen Glands			Skin Rash			Kidney/Urinary		
Fever/Chills			Drug Reaction					

3. Do you have any medical problems such as:

	YES	NO		YES	NO		YES	NO
Heart Problems			Diabetes			Seizures/Convulsions		
Physical Disability			Asthma			Other		

If other please explain \_\_\_\_\_

4. Do you think you have an infectious/communicable disease such as:

	YES	NO		YES	NO
Hepatitis/Liver Problem			Sexually Transmitted Disease (STD/VD)		
Mononucleosis			Other		

Please explain \_\_\_\_\_

5. Why do you think this? \_\_\_\_\_

6. Do you think you have been exposed to any communicable disease in the past 2-3 weeks? Yes \_\_\_\_\_ No \_\_\_\_\_

Why do you think this? \_\_\_\_\_

7. Are you taking any kind of medication or shots? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, What kind?/What for? \_\_\_\_\_

Name/Address of physician who ordered it \_\_\_\_\_

8. Are you allergic to anything like aspirin, foods, medicine, etc?

Specify \_\_\_\_\_

What happens? \_\_\_\_\_

9. For girls only: Do you take birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when did you take your last pill? \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

10. Have you ever tried to hurt yourself or others, or thought about or attempted to commit suicide? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when and how? \_\_\_\_\_

11. Have you used any street drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what kind and when? \_\_\_\_\_

12. Are you currently sexually active? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use any method of birth control or any protection? \_\_\_\_\_

13. Name/address of your family doctor \_\_\_\_\_

Approximate date of last visit: \_\_\_\_\_

*Record any observations such as personal appearance, mannerisms, ability to answer questions, indications that the youth may be using drugs, is suicidal, etc. Sign each note with professional signature.*

[illegible]

14. Medical care is needed? Yes \_\_\_\_\_ No \_\_\_\_\_

Medical care obtained (date): \_\_\_\_\_ (time) \_\_\_\_\_

Staff completing form \_\_\_\_\_ Date \_\_\_\_\_